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Nutrition Intake Form

Name of Client:____ Phone#_____________________________

Current Address:____ City:_______________________________

State:______ Zip:____________ Alt ph#________________________ D.O.B.______________ Age: _________

Email:____ Employer:__________________________

Emergency Contact:___________________________ Ph#________________________ Sex: Male or Female

Height: ________ Current Weight (upon waking, nude, after bathroom): _________ Pictures Attached: Front, Side & Back

Inches- Thigh_________ Hip_________ Waist_________ Chest_________ Women(under chest and top)_________ Arm__________

Fees and Dues:
To establish nutrition coaching services, member agrees to pay total for the (package/plan/program) **due at signing**.

Client Start date: ___________________ Program Choice and Price: __________________________

Additional Programs/Items/Packages must be paid at time of purchase.

Program dues for my chosen program, along with authorized client charges will be collected via cash/check or CC **per sign up date above**. All clients must be paid in full before the start of any services. I understand if I do not choose a program, I will be charged the per visit rate for all appointments and changes made to my program following my First visit.

Acceptance and Agreement
I hereby agree to accept and abide by the terms of this Client Application and Agreement. I understand that this client agreement is for a term of _____ **Days/ Weeks/ Months** and will continue unless cancelled by me. I understand the term of my program will only be good for the length of time noted and will be expired if unused within time limit. __________**Initials**

I UNDERSTAND THAT ALL PROGRAMS AND COACHING ARE PERSONALIZED FOR EACH CLIENT AND ARE PROPRITARY TO MIDLAND CHIROPRACTIC CORP, ITS OWNER AND STAFF. IF ANY CLIENT IS CAUGHT SHARING, SELLING, OR USING ANY OR ALL OF ITS SERVICES OR PROGRAMS CLIENT WILL BE DROPPED AND NO REFUND WILL BE GIVEN ON SERVICES UNUSED.

____ _________________
Client Date

New Client Instructions

Once I receive this information complete and signed begin developing your program and your Initial Visit Appointment to review will be set up. Please allow 3-7 business days for initial program completion.

1. How many days do you devote to training in the gym/extra activities noted below and for how long each session. Be honest as this is how your program will set up to follow. __________

2. Please give me an example of your current training/workout/activity program and include all Weight Lifting, Classes, Cardio and HIIT, Sports.

   Day 1

   Day 2

   Day 3

   Day 4

   Day 5

   Day 6

   Day 7

3. Please List all of the Medications, Supplements and Vitamins Currently Taking (for more in depth see page 6)

4. What is your sleep schedule and quality of sleep look like? How many days a week do you sleep less than 7 hours?

5. Please List all Workout and Eating restrictions, illnesses, and health concerns currently and within the last 2 years

6. Do you have a history of eating disorders? Anorexia Nervosa, Binge Eating Disorder, Bulimia Nervosa, Other. Please not how long each lasted or if current.

7. How Many Diets, Diet Programs, Coaching Programs have you had/done over your lifetime? Please describe in Depth.

8. Have you ever been categorized as obese? Yes or No   Highest Weight and Age?

9. Current Daily Water Intake? ________oz   Current Daily Pop Intake? _______oz Type__________

10. Current Daily Coffee Intake? ________oz   Current Daily Energy Drink Intake? _______oz

11. Do you smoke or use narcotics? Yes or No

12. Do you drink alcohol? Yes or No

    a. Beer-How Often/ Amount?
    b. Liquor- How Often/Amount?
    c. Wine- How Often/Amount?

13. Do you have support at home and around you to meet your current goals?

14. WHAT IS YOUR GOAL? Break It Down the Best You Can Starting From The Top

    a. 1-2 Year Goal

    b. 3-6 Month Goal

    c. 1-4 Week Goal

15. MyFitnessPal is a great tool to track food, the account is easy to set up and is free via App or Online

16. **Be Sure to take your pictures and email within 1 week of the start of your program. Pictures in a swimsuit or Shorts/underwear (and sports bra or tight tank for women) Take a picture in a relaxed pose Front whole body, either side of Choice Whole Body, and Back whole Body. Please try and take pictures in the same location wearing similar clothes each time requested.**

Medical History

Please check "yes" for any health conditions your doctor has diagnosed, and record approximate date of onset.

Condition	Yes	Since:	Condition	Yes	Since:
GASTROINTESTINAL			**INFLAMMATORY / AUTOIMMUNE**		
Irritable Bowel Syndrome			Chronic Fatigue Syndrome		
Inflammatory Bowel Disease			Rheumatoid Arthritis		
Chron's Disease			Lupus SLE		
Ulcerative Colitis			Frequent Infections		
Celiac Disease			Severe Infectious Disease		
Gastric or Peptic Ulcer Disease			Herpes		
GERD, reflux/ heartburn			Gout		
Hep. C or Liver Disease			Other:		
Food Intolerance					
Other:					
Asthma			Osteoarthritis		
Chronic Sinusitis			Chronic Pain		
Sleep Apnea			Fibromyalgia		
Bronchitis or Emphysema			Migraines		
Tuberculosis			Other:		
Other:					
CARDIOVASCULAR			**URINARY / REPRODUCTIVE**		
Heart Disease / Heart Attack			Kidney Stones		
Stroke			Urinary Tract Infections		
Elevated Cholesterol			Yeast Infection		
Irregular Heart Rate			Prostate Problems		
High Blood Pressure			Other:		
Other:					
NEUROLOGICAL / MENTAL			**METABOLIC / ENDOCRINE**		
Depression			Type I Diabetes		
Anxiety			Type II Diabetes		
Bipolar Disorder			Metabolic Syndrome		
ADD/ADHD			Hypoglycemia		
Multiple Sclerosis			Hypothyroidism		
Seizures			Hyperthyroidism		
Anorexia Nervosa			Polycystic Ovarian Syndrome		
Bulimia			Infertility		
Unspecified Eating Disorder			Other:		
Parkinson's Disease					
Other:					
DERMATOLOGICAL			**CANCER: Please list types / treatments**		
Eczema					
Psoriasis					
Acne					
Other:					

Any additional health conditions your doctor has diagnosed:

Please list any previous injuries, surgeries, and hospitalizations. Include age/date if known.

Your Birth History: Vaginal / C-Section	Were you breastfed as an infant? Yes / No

Family History

Has anyone in your immediate family been diagnosed with the following?

Condition	Yes	Family Member(s)	Age of Onset	Description
Heart Disease				
High Blood Pressure				
Stroke				
Diabetes				
Cancer				
Overweight				
Food Intolerance				
Autoimmune Disease				

Oral History

Do you visit a dentist twice per year?	Do you have silver/mercury fillings? Y / N How many?

Allergies		Symptoms Experienced
Food		
Medication		
Supplement		
Environmental		

Medications / Supplements: Please list all prescription medications, nutritional supplements, and herbs/botanicals you are currently taking.

Medication Name	How long?	Dosage	Frequency	Reason for taking

Herb/Supplement	How Long	Dosage	Frequency	Reason for taking

Have you had prolonged or regular use of NSAIDS? (Advil, Aleve, Motrin, Aspirin, etc.)	Y / N
Have you had prolonged or regular use of Tylenol?	Y / N
Have you had prolonged or regular use of acid-blocking drugs? (Zantac, Pepcid, etc.)	Y / N
Have you taken antibiotics more than 3 times per year?	Y / N
Have you taken antibiotics long term? (longer than 1 month continuously)	Y / N

Lifestyle Information

How do you normally deal with stress? What do you do to relax?

Environmental Exposures

What is your occupation?

Are you regularly exposed to any of the following? (circle any that apply)

Cigarette Smoke	Paint Fumes	Perfumes	Nail Polish
Auto Exhaust / Fumes	Chemicals	Dry-cleaned Clothes	Hair Dyes

Do you feel dizzy/ get headaches when exposed to strong chemical odors?
If yes, please explain:

Nutrition History

Have you ever had an appointment with a nutrition professional?

Have you ever changed your eating habits for a health reason?
If yes, please explain.

Are you currently following a particular diet?
If yes, please explain.

Do you avoid any particular foods?
Please explain.

Do you have any food intolerances / allergies?
Please explain.

Have you recently lost / gained weight?
Please explain.

How many meals / snacks do you eat in the average day?

How many meals do you buy from a restaurant each week?	0-1	2-3	4-6	>6

Do you use any natural/artificial sweeteners? Y / N Which ones?

What is your favorite meal?

Nutrition History (continued)

Circle any of the following that apply to your current eating habits / lifestyle:

Love to eat	Fast eater	Live alone/ eat alone often	Love to cook
Erratic eating patterns	Do not plan meals / menus	Emotional eater	Eat too much
Busy schedule / time constraints	Late night eater	Rely on convenience foods	Travel frequently
Struggle with eating issues	Eat fast food frequently	Eat only because I have to	Family members have different tastes
Poor snacking choices	Negative relationship with food	Confused about food / nutrition	Dislike healthy food
Don’t like to cook	Don’t know how to cook		

Food Diary: Please record a typical days food/beverage intake (3-7 Days)

Include Times you woke up, Times you ate, Time you went to Bed

Food Frequency Questionnaire: How often do you eat the following? Food	Never/ <4x per year	Rarely/ <4x per month	Once per Week	Twice per Week	3x per Week	Daily
Cheese						
Yogurt/kefir						
Dairy Milk						
Coconut/almond milk						
Red Meat						
Pork						
Processed meat (sausage, bacon, lunch meat)						
Chicken						
Eggs						
Cold water fish (wild salmon, herring, halibut, cod, etc)						
Other fish or shellfish – specify:						
Beans/Legumes						
Tofu, Tempeh						
Soy “meat alternative” (tofurkey, soy bacon, etc)						
Berries						
Other fruit – Specify:						
Cruciferous Vegetables (cabbage, broccoli, brussels sprouts)						
Green Leafy Vegetables						
Yellow fruits and veg. (peppers, corn)						
Other green fruits and veg. (peas, avocado, cucumbers)						
Blue/purple fruits and veg. (blueberries, prunes, beets, cabbage)						
Red fruits and veg. (cherries, apples, tomatoes)						
Orange fruits and veg. (orange, carrots, sweet potato)						
White/tan fruits and veg. (onion, garlic)						
Turmeric, cumin, ginger, rosemary, oregano, parsley						
Nut Butters – Specify:						
Avocado, extra virgin olive oil, coconut oil						
Vegetable oil (corn, sunflower, etc)						
Butter / Ghee						
White Rice						
White Bread						
White Pasta						
Bagels / Muffins						
Pancakes / Waffles						
Chips/pretzels						

Popcorn						
Crackers / other snack food						
Whole Wheat, Rye, Barley Bread / Pasta						
Other Whole Grains (quinoa, oats, brown rice, etc.)						
Ice Cream						
Pastries, Cookies, Cakes						
Juice – Specify:						
Lemonade/Sweet Tea						
Diet Soda						
Regular Soda						
Tea (white, green, black)						

Daily Intake Summary What type of protein do you consume most days of the week? Mark all that apply.					
Animal Meat	Beans	Eggs	Soy-Based	Dairy	Nuts / Seeds
How many servings of fruit per day?			How many servings of vegetables per day?		